Skillcare Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 16 and 17 April 2018 and the first day of the inspection was unannounced. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults some of whom have physical disabilities and are living with dementia. At the time of inspection, there were 23 people receiving personal care from Skillcare Limited.

Skillcare Limited had been in special measures since our inspection in April 2016. Following an inspection in April 2017, CQC issued a Notice of Proposal to cancel the provider's registration. We inspected in August 2017 to see if improvements had been made and following this inspection, we issued a Notice of Decision to cancel the provider's registration. The provider appealed our decision to the First Tier Tribunal.

In January 2018 we carried out an inspection to assess if the provider had made improvements. At that inspection, in addition to ongoing concerns regarding risk assessing and medicines management, we identified concerns around staffing levels and deployment of care staff and recruitment. Due to the concerns identified at that inspection, CQC confirmed their decision to cancel the providers registration and as an additional measure, imposed a condition on the provider's registration to restrict the taking on of new care packages without CQC authorisation. The provider appealed this decision to First Tier Tribunal.

We carried out this inspection to assess whether the provider had made improvements prior to the Tribunal which had been scheduled for May 2018. At this comprehensive inspection we found the provider had taken action to achieve compliance with all of the regulations previously identified as non-compliant during the comprehensive inspection in January 2018. Because of the improvements seen, CQC withdrew their notice to cancel the provider's registration. We agreed with the provider that the condition to restrict them from providing a service to new people would remain on their registration, however CQC would permit the provider to provide personal care to no more than five new people per month. CQC will reassess the condition in place at a future inspection.

The service had a registered manager. In this report we will refer to this person as the 'provider' as they were also the director of the company. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection, we found detailed current risk assessments were in place for people using the service. Risk assessments explained the signs to look for when assessing the situation and the least restrictive ways of mitigating the risk based on the individual needs of the person.

The provider had made improvements to how medicines were managed. Medicines Administration Records were completed appropriately. Staff had received recent medicines training and there was an improved

oversight of how medicines were managed.

At this inspection, we found that the provider's oversight of care visits and staff rotas had improved. We received mostly positive feedback from people and relatives regarding timeliness of care visits. The provider had recently introduced an electronic call monitoring system which enabled them to monitor all care visits. However, we identified that care staff were not always staying for the full duration of the care visit.

Since the last inspection, the provider had recruited three care staff, one of which at the time of inspection was providing care. We found that some improvements had been made to how the pre-employment checks had been carried out.

We found that care plans were person centred and reflected what was important to the person. Care plans provided appropriate guidance to enable staff to deliver person centred care in line with people's preferences.

We received positive feedback from people and relatives regarding the caring nature of staff and their overall experiences with the provider.

Staff received regular training, supervisions and an annual appraisal. The provider had oversight of staff training needs.

We found that improved systems were in place to monitor and check the quality of care provided. We received consistently positive feedback from staff regarding the management structure in place and the support they received. Managerial oversight of the service had improved since the last inspection. Good practice had been developed, but further time was needed for the service to demonstrate that the improvements that had already been made had been fully embedded and could be sustained.

The provider has demonstrated significant improvements and as the service is no longer rated as inadequate for any of the five key questions, it is no longer in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

This service has improved from Inadequate to Requires Improvement. There were sufficient staff deployed to meet people's needs. However, some care visits had been completed in a shorter time than allocated.

People told us they felt safe. Staff knew how to identify and raise concerns about people's safety.

Risk assessments were in place to manage the risk and keep people safe. People received their medicines as prescribed.

Improvements had been made to how staff were safely recruited.

Is the service effective?

Requires Improvement

The service was now more effective. People were supported by staff who had the training and knowledge to support them effectively.

Staff received support and supervision and had access to training and development.

People were given the assistance they required to access healthcare services and maintain good health.

People told us they were supported with their nutrition and hydration needs.

Is the service caring?

Good

The service was now caring. People and relatives spoke positively about staff. People were treated with dignity and respect.

Care plans were detailed and provided information about people's needs, likes and dislikes. People and relatives told us they were involved in planning their care.

People were treated as individuals and their diverse needs respected.

Is the service responsive?

Requires Improvement

The service was now responsive. Care plans detailed people's individual care needs and had been recently been reviewed.

People using the service told us they would speak to staff if they were not happy with any aspect of the care and support they received. Complaints had been investigated and appropriately responded to.

Is the service well-led?

Requires Improvement

This service was not always well led. Systems were in place to ensure the quality of the service people received was assessed and monitored. We saw improvements had been made in this area. We could not rate the service higher than requires improvement for 'well-led' because to do so requires consistent and sustained improvement over time. We will check this during our next planned comprehensive inspection.

Staff spoke positively of the registered manager and the support they received.

The provider was working with health and social care professionals to address the findings of the last inspection.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 and 17 April 2018 and the first day of the inspection was unannounced.

The inspection was carried out by two adult social care inspectors and one expert by experience who made telephone calls to people who use the service and family members. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of caring for somebody who received personal care in their own home.

Before the inspection we sought feedback from the commissioning local authority. We reviewed notifications submitted by the provider. Notifications are reports of events or incidents that provider are required to tell us about by law.

During the inspection we spoke with the registered manager, compliance manager and six staff members. We spoke with five people who used the service and five relatives. During the inspection we reviewed seven people's care records including their needs assessments, risk assessments, care plans and records of care delivered. We reviewed seven staff records including recruitment, supervision and training. We reviewed call monitoring information, quality audits, meeting records and various policies, procedures and other documents relevant to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in January 2018 the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to concerns around how medicines were safely managed and how the service assessed risks to people associated with their health and care needs. At this inspection, we found that the provider had made improvements to how medicines were managed and how risks were assessed.

At the last inspection, we saw that where people had been prescribed antibiotics, they had not been accurately recorded on the Medicines Administration Record (MAR). MARs had not been updated when people's prescribed medicines changed. The application of topical medicines such as creams was not accurately recorded. There were gaps on MARs and audits had not picked up concerns.

Most people and relatives we spoke with told us they had no concerns with how medicines were managed. One person told us, "They give [medicines] to me and I take it myself." A relative told us, "Yes they give him his medication. He has 20 or 30 pills a day they are in a dosette box." One relative raised concerns with how their loved one was supported with medicines. We informed the provider of the concerns raised and they confirmed that they would investigate.

Since the last inspection, the provider had carried out a review of all people's medicines records and MARs now accurately reflected medicines people had been prescribed. Most MARs seen contained no gaps in recording or errors. Where we saw a gap on a MAR, the provider explained that the MAR had been removed from the person's home for auditing, which was confirmed by records seen. Staff were now appropriately using codes to explain instances when a medicine was not administered, for example, if the person refused the medicine.

MAR charts were audited on a regular basis and where a discrepancy had been noted, this was investigated. For example, a MAR audit identified that medicine for the relief of constipation was not on the person's MAR, however on investigation, it was identified that the person's family were responsible for the administration of this medicine.

We checked the provider's training records and saw that all staff had received medicines training and had a competency assessment. In addition, since the last inspection, staff received additional training around completing MARs and the application of patch medicines.

When we last inspected in January 2018, we found that although the service had demonstrated that they had made some improvements to how risks associated with people's care were assessed, we found some instance of known risks not been assessed. At this inspection, we found that the provider had made improvements to how the service assessed risks and provided guidance to care staff to keep people safe.

Following the last inspection, the provider had reviewed and updated people's risk assessments. Where a person had a health condition such as diabetes, arthritis or repeated infections, their risk assessment

identified how the health condition impacted on them and provided guidance to staff should the person experience ill-health.

Where a person had been assessed as at risk of acquiring a pressure ulcer, detailed guidance was given to staff on how to identify concerns. We saw that where a person was at risk of a pressure ulcer, records seen confirmed that staff were checking the person's skin integrity and repositioning the person if required.

For another person, their moving and handling risk assessment advised staff to allow extra time for this task, as the person experienced a twitching limb. For another identified risk, their assessment stated that due to a medical condition, very warm weather can make the person very tired. This information helped staff to care for a person safely.

At the last inspection, we identified significant concerns with staffing levels and how care staff were deployed, which impacted on the level of care people received. Rotas showed that care visits were scheduled either back to back, overlapped or concurrently. The provider had poor oversight of care visits and whether care staff were attending people's care visits as scheduled. As a result of our significant concerns, we imposed a condition on the provider's registration where they were unable to provide care to new people without the written authorisation of CQC.

At this inspection, we saw that the provider had made improvements to how care visits were scheduled and managed. Staffing levels were sufficient to cover the number of care visits scheduled. Staff told us that they had no concerns with how their rotas were scheduled and confirmed that they had sufficient travel time. The provider now had systems in place to enable them to actively monitor the timeliness of care visits. However, we identified some concerns with care staff not staying the full duration of the scheduled care visit.

People and relatives were generally positive when asked if they received care visits on time. They told us that staff carried out all tasks required. One person told us, "No problems, they come on time, sometimes they are late and the office phones me." A second person told us, "Give or take 5 or 10 minutes." A third person told us, "Yes generally on time give or take 15 minutes, I am insulin dependent. I need to know what time they are coming back. Today they said they were coming back at 3pm. I don't mind as long as I know."

A relative told us, "Occasionally they are late 10 or 20 minutes." A second relative told us, "They come on time." Most people and relatives told us that they were kept updated if care staff were running late. One relative told us that the service had improved in this regard. One relative raised concerns regarding the timing of care calls and missed care visits. We raised these concerns with the provider who advised that they would investigate. Nobody we spoke with told us that they had any concerns about staffing levels and told us that if two care staff were required to attend a care visit, two care staff attended, which was confirmed on review of electronic call records.

We checked rotas and saw that care staff had a minimum of five minutes to travel between care calls depending on location and had not been allocated overlapping or concurrent care visits. The provider had installed an electronic care monitoring system one month prior to the inspection. When we inspected, all staff had been equipped with the software to log in and out of care visits and we could see that all care visits had been recorded. However, we found a number of instances of care staff not staying the full duration of the scheduled care visit. For example, on one route, two care staff had been scheduled to complete eleven care visits for three people on one day. Of the 11 scheduled visits, five were on time and full duration, one visit was extended by 15 minutes and five care visits were completed 15 minutes quicker than the scheduled 30 or 45 minutes. On two of these care visits, the care calls started over 45 minutes after than the scheduled

start time.

On a second route, two care staff were scheduled to complete 14 care visits for five people. Of the 14 scheduled visits, four were on time and for full duration, four 45 minute calls were cut short by 25-30 minutes, two 30 minutes visits were completed in 10 minutes and four 30 minute visits were completed in 15-20 minutes.

We discussed our concerns with the provider, who advised that the people affected by the shortened care visits had family present and requested that care staff did not stay the full duration of the care visit once they had completed their allocated tasks or people had asked care staff to attend the care visit at a different agreed time. The provider also told us that they had recently introduced a daily audit of the electronic call monitoring system which checked a random sample of care visits. At the time of inspection, the audit had been in operation for two days and had not yet been addressed any concerns with timing and length of care visits.

When we last inspected in January 2018, we identified concerns with how staff were safely recruited. Application forms did not contain full employment history and gaps in employment had not been explored. References were not always obtained prior to the staff member commencing employment and not obtained from a previous employer. At this inspection, we found that the provider had made some improvements, however we remained concerned about how employment references were obtained. Following the last inspection, the provider had completed a check of recruitment records and previously recruited staff now had complete employment histories and appropriate references. DBS checks were now in place for all staff. For newly recruited staff, we found that ID checks, DBS checks and an employment history had been obtained. We identified concerns with the authenticity of one reference. The provider contacted the referee to confirm the reference and requested an additional reference for the staff member involved.

People told us that they felt safe when they were receiving care from Skillcare Limited. One person told us, "Very safe. I have a call in the evening to help me with my bath." A second person told us, "More or less. I am getting to know them. I feel safe." A relative told us, "They are exceptional carers. They look after him very well." Staff understood how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. All staff had received training in safeguarding adults from abuse. Staff told us that if they would report any concerns they had to management. Staff told us they were confident any concerns would be addressed.

We looked at how the service recorded and investigated incidents and accidents. There were six reported incidents since our last inspection which included people being unwell and requiring staff to contact the emergency services and issues with key safes. Incidents were appropriately investigated and records documented the action taken by the service to ensure the person was safe at the time of the incident and any wider learning from the incident.

Care staff told us they had access to sufficient Personal Protective Equipment (PPE) which is disposable gloves and aprons to help prevent the risk of infection. Staff were provided with PPE at regular staff meetings.

Requires Improvement

Is the service effective?

Our findings

People and their relatives were mostly positive about staff and told us they were skilled to meet their needs. Feedback from people in this regard included, "They do - they know what's wrong with me and how to handle me" and "I have a good understanding with my carer." A relative told us, "Yes they are well trained."

Staff spoke positively of the training and support they received. One staff member told us, "I get quite a few trainings. Last training was CPR, first aid, moving and handling, medicines. Lots of training. Face to face. They engage us and show you the physical stuff." A second staff member told us, "We did hoisting training in the office." A third staff member told us, "[Training] helps us to learn. They help us." Training records confirmed that all staff were up to date with their mandatory training which included infection prevention and control, medicines, first aid, moving and handling and writing skills.

New staff completed an induction course. This was a mixture of classroom and e-learning and included the mandatory training courses. During the inspection, we observed training delivered by a field care supervisor to a newly recruited staff member. The training was delivered on a one to one basis. The training was around record keeping with case studies. The training included a competency assessment and we observed the field care supervisor relay the importance of accurate record keeping to the staff member.

Staff told us that they had regular supervision with a member of the management team which was confirmed by records seen. We saw that supervisions were done in a combination of ways, a spot check in a person's home, a one to one meeting or as group supervision. The provider kept an overview of when staff supervisions and appraisals were due.

Following the last inspection, CQC imposed a condition on the provider's registration which meant they did not commence any new care packages. Therefore, at this inspection, we were unable to check whether the provider had made improvements to how they initially assessed peoples care needs and how that information formed the basis of a person centred care plan. We will check this again at a future inspection.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this must be made through the Court of Protection for people living in the community. If people living in their own homes are receiving restrictive care that may amount to a deprivation of their liberty, an application must be made to the Court of Protection to ensure that restrictive care is lawful and in a person's best interests.

As noted above, since the last inspection, the provider had not taken on any new care packages, therefore we were unable to check that provider had complied with MCA in this regard. We saw that all staff employed had updated MCA training. Most people told us that staff obtained their consent before providing care. One

person told us, "They just do it as they know it helps me." Staff understood the importance of MCA and how it impacted on their role. One staff member told us, "It is important for people with dementia. You have to know what they are capable of deciding for themselves."

Most people receiving care and support required only minimal assistance with meals which included preparing a ready meal or assistance with making snacks and drinks. People's care plans detailed their food likes and dislikes and what support the person needed from care staff such as when families prepared meals. One person's care plan stated that they were vegetarian and did not eat eggs. Where people required support with meal preparation or eating and drinking, we received positive feedback. One person told us, "Yes they make me a sandwich or eat a prepared meal." A second person told us, "Yes ready meals. They put them in microwave." A third person told us, "They fill up mugs with water for me." A relative told us, "We cook her food. They heat it up."

Some people told us that they were supported to access health services. However, many people and relatives we spoke to did not require assistance from the provider to access healthcare services as domiciliary care agencies do not generally support people with healthcare appointments. People told us and records confirmed that care staff had escalated concerns they had to the emergency services, when needed. One person told us, "Yes a couple of weeks ago, I had blood in my urine and they called an ambulance for me."

We saw that the provider had worked in partnership with external agencies, such as the local placing authority and health professionals such as occupational therapists. Care staff documented in daily notes when health professionals such as GP or district nurse visited the person.

We could not rate this key question as good because we need to check aspects of this key question at a future inspection when the service provides care to new people. We also need to ensure the improvements are sustained over a period of time.

Good

Is the service caring?

Our findings

Most people and relatives told us that staff were caring and kind. Feedback included, "Yes definitely, I can't complain with their manners. Sometimes they watch TV with me or chat"; "They treat my mother very good", "First Class" and "Of course - yes they are loving and caring." People told us that they had regular carers which meant that they could build relationships and get to know their care staff and vice versa. A staff member told us, "I have been working with [person] for two years. I know them and their family quite well."

We reviewed compliments received from people and relatives who used the service which included a number of thank you cards. One compliment noted was from a person who had received assistance from the provider out of office hours during ill-health. The provider had arranged for emergency services to attend.

People told us staff respected their privacy and dignity and were treated with respect. A relative told us, "Yes, they close her curtains and will shut her door." People also told us their preferences for gender of care staff was respected. One person told us, "I prefer to have a female carer." A second person told us, "I am satisfied with the carers I have got."

People told us that where possible, care staff supported them to remain independent. One person told us, "Yes if they can. I am bed bound." A second person told us, "Yes they take me to the shops and have a coffee."

Most people and relatives told us they were involved in planning their care. Care needs assessments documented that people and their families, where possible were involved in the process. One person told us when asked if they were involved in planning their care, "Originally yes." A second person told us they were involved in a review of their care package, "about three weeks ago." A relative told us, "Continually reviewed. I see [registered manager] occasionally."

Care plans detailed people's cultural and religious preferences. The provider told us that many of the people receiving care had religious and cultural requirements which the service facilitated. One relative told us, "They are very caring. Because of my father's death. We have some religious rituals that we carry out and they have been very understanding about it." A second relative told us, "Yes they do. They put shoe coverings on when they come in the house."

Requires Improvement

Is the service responsive?

Our findings

We looked at complaints received by the service since we last inspected and saw that four complaints had been logged and investigated. Complaints documented related to people being unhappy with the conduct of care staff and times of care visits. Complaints had been logged, investigated and responded to, with an apology if appropriate. Where the provider had identified an area for learning or improvement, such as additional staff training or supervision, this had been done.

Most people and relatives told us that they had no complaints and any concerns raised previously had been addressed. People and relatives also told us that they felt the provider would take any concerns raised seriously. One person told us, "I complained about not having the same carer and asked for a particular carer at about the end of January. Now I have two carers." A relative told us, "They were using the hoist instead of a wheelchair to transport her. This only happened with the new operatives. We raised this six weeks ago with the management." The relative confirmed that this issue had been resolved. A second relative told us, "They try to get it really good, they listen to me. They are improving the service. They try their best." One relative told us they were not happy regarding their experience of raising concerns which we raised with the provider, who told us they would investigate.

People, relatives and care staff told us that there were care plans in place in people's homes. People's care visits were documented by care staff. We found that the records kept were comprehensive and person centred with care staff recording what the person had to eat if they were being supported at a mealtime. In addition, we saw examples of care staff recording where there had been professional involvement such as district nurse or GP.

As noted already, since the last inspection in January 2018, the provider had not taken on any new care packages and therefore had not carried out the care planning process from initial assessment. When we last inspected, we were concerned that the new care plans the provider had introduced were not person-centred and task focused. The provider had reviewed all care records and introduced person-centred care plans. Where a person had multiple daily calls from the agency, each of these calls were written separately within the care plan and the tasks to be performed for each visit were clearly identified. Care plans also documented people's medical conditions by detailing the type of medical condition and the symptoms a person may display if they were experiencing ill health. Guidance was given to staff on what to do should the person experience ill health.

Care plans also detailed the person's social history, family involvement, mental cognition, skin integrity, mobility needs, eating and drinking. One person's care plan which had been reviewed in March 2018 referred to the person's recent hospital admissions and changes to their care needs following discharge. Another person's care plan detailed that they liked their feet soaked every morning. Care plans detailed that care staff should be aware that people's wishes may change on a daily basis depending on how they were feeling and if they were experiencing pain. This was evidence of care plans being responsive to people's changing needs.

We could not rate this key question as good because we need to check aspects of this key question at a future inspection when the service provides care to new people. We also need to ensure the improvements are sustained over a period of time.

Requires Improvement

Is the service well-led?

Our findings

Most people and relatives gave us positive feedback regarding their overall experience with receiving care from Skillcare Limited. People and relatives knew the management team and told us they could contact them if they had any concerns. A person told us, "Before my main carer left I would have been happy to recommend them. Now the service is okay." A second person told us, "Yes with me they are okay." A relative told us, "The service has been quite good. It has been improving." A second relative told us, "Certainly the group of carers are saints."

We received positive feedback from staff regarding the management of the service and the support they received from office based staff. A staff member told us, "They [office] help me. If I call them to ask something, they will call me back." A second staff member told us, "The managers are very good. Everyone communicates." A third staff member told us, "If I have a problem. They answer my call at any time."

When we last inspected, we saw that the provider had not displayed their rating from their previous inspection in August 2017. At the time of drafting this report, we checked the provider's website and saw that the rating from the January 2018 inspection had been displayed as required.

At our last inspection, we found a lack of managerial oversight in relation to staffing levels and rota management, risk assessments, medicines management and staff recruitment. At this inspection we found significant improvements had been made in these areas as detailed throughout the report. The provider told us that they had worked hard to make improvements. The provider told us, "We are committed. We are going in the right direction." Risk assessments identified individual risks and provided guidance to staff to understand and mitigate the risks posed to people. Improvements had been seen to how medicines were safely managed. We noted that since the last inspection, the provider had not recruited many care staff. We saw that missing information such as references and employment histories had been obtained for already recruited care staff.

We saw that improvements had been made to how care visits were scheduled and people were more positive at this inspection about their experiences with the timeliness of care visits. The provider had introduced a new electronic call monitoring system which could monitor all care visits made. However, on review of some sample days visit logs, we identified that a number of care staff were not staying with the person for the duration of the care visit. We discussed this at length with the provider and compliance manager who told us that some people did not want care staff to stay in their home once their care tasks had been completed, however this was not recorded in care records. At the time of the inspection, the provider and compliance manager had not yet embedded a system for documenting actions taken if concerns had been identified with care visits such as late or shortened care visits. We referred our concerns about shortened care visits to the provider's main placing authority.

The provider had established a mentoring relationship with a peer colleague. The provider told us the mentor was providing guidance on policies, procedures, and making improvements to care planning and risk management. The provider told us that the mentor had been very helpful.

Since the last inspection, the provider had reviewed their quality assurance processes. The provider had developed a new quality monitoring report based on the CQC Key lines of enquiry. The audit assessed missed and late visits, complaints, incidents and accidents, outcome of feedback surveys, training and recruitment. The report also had scope for the provider to identify emerging trends such as complaints or late or missed care visits, however at the time of inspection, had not identified concerns with length of care visits.

At the time of inspection, the revised quality monitoring report had been in use for one month. We discussed the sustainability of the quality monitoring measures in place with the provider and compliance manager who both reiterated that the improved quality monitoring in place since the last inspection would remain and continue to embed, especially with regards to monitoring of care visits. We will assess the effectiveness and sustainability of the provider's quality monitoring at a future inspection.

The provider also assessed quality of care through regular spot checks and requesting feedback from people and relatives. Most people and relatives told us that they were regularly contacted to provide feedback on the service they received. One person told us, "Yes not long ago." One relative told us, "We had some forms sent to us." A second relative told us, "They do over the phone ask about the care." Feedback seen was overall positive.

The provider had worked with their main placing authority. We received positive feedback from the placing authority regarding improvements made by the provider in addressing areas of concern identified at previous CQC inspections.